THE Dental Assistant

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ASSOCIATION

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The Dental Assistant

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DENTAL DIVISION

The President Speaks...

It will be through the medium of this page that I shall be able to visit with the greater number of members of the American Dental Assistants Association, and it is my sincere wish that each visit be not only a friendly one, but also one of assistance.

In looking ahead to the coming year, I could not help but review the accomplishments of this association. When we stop to consider how much nearer we are to the goal for which we have been striving, we realize the many steps we have made are the results of the efforts of loyal dental assistants. But, if we are to reach the final goal, now is not the time to sit back with complacency. Only through PERSEVERANCE on our part will the efforts of the past be worthwhile. This does not apply to one particular phase of the association, but to everything that will promote its growth and development. This means we must give particular attention to EDUCATION — MEMBERSHIP — PUBLIC RELATIONS — and above all to FRIENDSHIP.

Indeed, this is a great undertaking, and cannot be accomplished by just a few individuals. It cannot all be done at the national level! It depends upon each individual member in each local society!

Share the benefits of your membership in the local, state and ADAA with a non-member dental assistant. Your friendly gesture will bring personal dividends in a new friend. She will lessen your responsibilities in reaching our goal by picking up part of them.

Join me in striving for one of the greatest circles ever known — One of Friendship — all dental assistants.

In Friendship,

ELMA TROUTMAN, *President*

Editorial

INVEST NOW For Future Security

At this press time we are approaching the dawn of another bright, New Year. All over the world people will be exchanging greetings of "Happy New Year" with loved ones and friends, and this is all well and good.

We wonder, however, how many of us have really given any serious thought to what we will do in those 365 bright, new days; those 8,760 hours that, God willing, lie ahead for each of us. Have we a program, a plan, a goal to work toward, or do we expect to just wander aimlessly through each day letting come what may? If you are among the latter group, how about getting busy right now and make some plans to use those hours, that will be given to many of us, to a good advantage.

In a normal 50 week working year most of us will spend 250 days or 2,000 hours in our work; 2,920 hours should be given for sleep and restoration of our energies, and this leaves 3,860 hours free for recreation and to devote to outside duties and interests. How many of those free hours have you budgeted to spend working in your dental assistants association? Time passes swiftly and by the time you read this some of those precious hours will have gone by. But the greatest part will be still ahead for you, so, why not start right now to plan to use some of them to accomplish something really worthwhile in your dental assistants association.

We have passed another milestone in our association life together. Looking backward to Dallas, we recall the reports at the annual session which gave evidence that we are becoming a mature organization. With the growth we have already experienced and the continued healthy growth we can envisage for the future, each member can take comfort in the enhanced security that this maturity brings to those who are engaged in the vocation of dental assisting. But, as our President tells us in her message in this issue, "This is not the time to sit back with complacency. Only through Perseverance will the efforts of the past be worthwhile." It is up to us as individual members to be persistent in the plans for our organization's progress and growth.

It is apparent that much of the weakness in our program stems from the lack of interest and cooperation at the local level. If your leaders are weak and indifferent, if your programs are uninteresting and lifeless, if your members are disinterested and uncooperative — your meetings poorly attended — it is time for you, as a group, to do something about it. Take inventory, decide what is wrong, and take steps to correct the situation. If you are just coasting along, going through the motions, is it really worth any effort at all? Sure, it will take a little time and effort to put some life in the society, but it will be worthwhile.

(Continued on next page)

If the individual member is not sufficiently interested in her career in dental assisting to attend really good lectures and clinics, to take the Study Course when it is available to her, to participate in the programs of her society, all in line with self-improvement, she is not deserving of, or prepared for, recognition as an effective member of the dental health team. In time, she will be left behind—replaced by a more effective, alive person. The first move in a forward direction, however, is up to the officers. There is no time in those free hours in 1959 for indifference, pettiness, politics or "lazy streaks"—we must get busy with a constructive, active program.

If you do not have strong leadership, elect some members who will do the job, and then support them as they prepare a program. If you do not have a program outlined a year in advance, get busy and plan one and put it into action in 1959. The member who means well, but "just doesn't have it, and won't try to get it" is a detriment to your society. Let her know she must "get on the beam" or be left by the wayside, and chances are she will step up her pace and enjoy her association life far more because you gave her a push upward. We are all busy, our schedules are full, the pace is rapid for all of us these days, but surely there are some of those 3,860 free hours that we can devote to making our local, state and national associations strong and worthwhile in 1959.

To receive dividends, we must invest; all we are asking you to invest is a fair share of your free hours. How about it?

From Central Office Wires

ADAA Memberships for 1959 are due and payable. Please cooperate with your local and state officers in getting your memberships on record promptly.

It is important that changes of name and address be reported to both State Secretaries and the ADAA Central Office.

Copies of sample by-laws for local secretaries and for state associations are available, upon request, from Central Office. Please state whether you want the "Business Body", or "House of Delegates" method of representation for your State by-laws.

Please continue your efforts for increased membership. There is much interest in the dental assistants associations and their aims and accomplishments. Invite the new assistants in your building or neighborhood, and make them welcome when they attend your meetings.

ADAA Information Booklets are available upon request for use in your membership efforts.

EDUCATION ..... EFFICIENCY ..... LOYALTY ..... SERVICE

Efficiency In Office Management*

By JOHN C. BRAUER, D.D.S., M.Sc. **

This subject warrants the immediate interest and attention of every dentist, dental assistant, and any other personnel which may be associated with a dental office. Efficiency in office management will reflect favorably in the potentials for a greater service to patients, and thereby a greater net income for the dentist and the dental assistant. Equally significant is the favorable impact that "office operational economy" will have upon the dental manpower needs of the country. The shortage in the number of dentists and auxiliary personnel which presently exists in the country is well-known and documented, and the vast increases in population in the next decade warrant a most serious consideration of the problem.

There are many factors which might be considered in a discussion of this important topic "Efficiency In Office Management." However, this presentation will be limited to a consideration of: (a) values in the use of the dental assistant, (b) employment and distribution of the dental assistant, (c) training the dental assistant, (d) training and philosophy of the dentist, (e) plan of office operation, and (f) office design.

Values In the Use of the Dental Assistant. That the dental assistant is an extremely valuable and important member of the health team has been recognized by *too few dentists, dental educators,* and others. The following statements present in part some of the tangible values. Coomer, using as a reference the evaluating committee reports of the University of Michigan workshop study how scientific dental service might be organized to care for more people, says:[1]

> The dentist increases his weekly patient load approximately 36.8 per cent by employing one auxliiary, and 68.8 per cent when he employs a second. Thus, if the dentist working alone is able to render an adequate service for ten patients per day, he will be able to serve 16 to 18 patients in the same time if he intelligently uses the services of two well-trained employees provided he has at least two, preferably three, well-equipped operating rooms, and that his office is efficiently designed and adequately equipped."

In the 1953 survey of dental practice by the Bureau of Economic Research and Statistics of the American Dental Association[2], the summary included the following statement:

> "Dentists with one auxiliary employee average 53.8 per cent more patients than dentists with no employees; with two employees, 219.3 per cent. The percentage increase in number of patients with number of employees for an entire year, as determined in this survey, was considerably greater than the increase in number of patients during a week, as determined in the 1950 Survey of the Dental Profession."

Employment and Distribution of the Dental Assistant. The 1956 survey[3] showed 22.9 per cent of the independent dentists in the United States had no employees, ranging from 11.0 per cent in the Far West to 40.0 per cent in the Middle East. A total of 69.5 per cent of the independent dentists in 1955 employed full-time assistant, and 8.6 per cent employed full-time dental hygienists. Only 5.1 per cent of the dentists employed two assistants. The per-

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* *Presented at annual meeting of American Dental Assistants Association, Dallas, Texas, November 12, 1958.*

***Dean, School of Dentistry, University of North Carolina, Chapel Hill.*

centage of dentists employing auxiliary personnel of any type increased from 73.1 per cent in 1952 to 77.1 per cent in 1955.

While the latter cited figures refer to the percentages of dental assistants employed, another consideration would be an evaluation of the relative efficiency or economy realized from such employment. Accordingly, an important question arises, what percentage of the assistants presently employed are 40, 50, 75 or perhaps, 90 per cent efficient in "present day acepted standards of dental assisting?" Many hundreds of thousands of hours are lost to the profession annually by the on-the- job method of training by dentists who have never been trained in how to use a dental assistant effectively. Unfortunately, in a few months or perhaps two or five years, this process is repeated because the girl changes her plans. Accordingly, the manpower waste is tremendous.

Training the Dental Assistant. The American Dental Assistants Association, through its forward-looking and vigorous leadership, has long recognized the importance of more adequate training for the assistant. The activation of the 104 hour extension course has given positive direction and help to thousands of girls throughout the country, and, thereby, the A.D.A.A. has made a great contribution to American Dentistry. Fortunately, too, there have been established some excellent schools for the education and training of dental assistants, which are offering one and two year courses of instruction. Many more schools are needed throughout the country.

Unfortunately, the dental profession in the past has given little official recognition to the training of dental assistants, and, to date, the major credit must be given to the active members of the A.D.A.A. However, in certain areas of the country, the dental profession has given strong support and leadership for a number of years. Extremely important, too, to the dental assistant and to the profession is the recommendation made by the Council on Dental Education to the House of Delegates of the American Dental Association in 1956[4], that dental students be trained in the use of auxiliary personnel. Furthermore, the Council on Dental Education in a workshop in Chicago, approximately a year ago, began to approach the important question of requirements for the formal training of the dental assistant. Likewise, the Dental Resources Division of the U. S. Public Health Service has directed its attention to the valuation and training of this source of dental manpower, and, accordingly, it is supporting financially a number of schools of dentistry in studies applicable to the problem.

To date opinions vary widely as to what knowledge and skills a dental assistant should have for the best interests of the profession. Some in the profession would encourage chair-side assisting only whereas others would extend the assistant's knowledge and skills to include many additional activities. Formal training, in the few schools in which it is now available, varies from the two year curriculum to the 10 week concentrated schedule in the Armed Forces.

Several important questions should be answered; namely, (1) what are the basic areas of knowledge and skills, which are expected by the profession's present day philosophy of practice and (2) what is the most practical and economical way of making such auxiliary personnel available? The Bureau of Economic Research and Statistics in mid-1955 showed that 22.9 per cent of the dentists had no employees and only 69.5 per cent had full-time assistants. Recognizing that 78,000 dentists were engaged in private practice (1955), the data would indicate that about 23,790 dentists did not have a full-time assistant and that some 17,800 did not have any employees. Assuming that the data presented by the Bureau

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are reasonably correct and that the dentist has a greatly increased potential for dental service with two dental assistants, the immediate training needs would be for approximately 100,000 assistants.

Can the profession logically require a two year education and training experience for the average assistant, as is now required for the hygienist, considering the vast number of assistants now needed, the costs of such training and the high percentage of annual loss of such employees? The answer is obvious, if the profession plans to approach the manpower problem in a practical and economical way. This does not imply that the two year curriculum for the training of dental assistants, is not desirable or excellent. The girl, who can realize a two, three, or four year college experience is fortunate and will accrue many advantages, and every encouragement should be given girls to attend such education and training programs. Furthermore, encouragement should be given to the activation of additional two-year programs. However, the program of procurement of an adequate number of qualified high school graduates presents a great challenge to the profession. The number of families that can afford a 3, 6, or a 12 month training experience for a daughter is far larger than the number who are financially able to send a daughter to school for two years or more. The number of qualified applicants annually for the dental hygiene programs (approximately 3,000) warrants the conclusion that the dental manpower problem cannot be successfully approached at this time with auxiliary personnel for which two years of formal training are required.

Another interesting and important factor relates to the question of how many of the 24,000 dentists who now do not employ a part-time or a full-time dental assistant would employ one or two full-time assistants if well-trained girls were available. Furthermore, how many of the 54,600 dentists (69.5 per cent) who now have a full-time assistant would employ another assistant? In other words, perhaps the profession needs 100,000 additional dental assistants now, but what is the potential effective demand for such trained personnel? Is the training of the dentists in how to use an assistant effectively one of the immediate and great problems? In my opinion, the real problem lies in the lack of training or appreciation on the part of the dentists. The solution to this problem lies in the main with the dental schools, wherein it is their obligation to teach the dental student how to use effectively the dental assistant.

Training and Philosophy of the Dentist. The average dentist has received little, if any, training in how to use effectively a dental assistant while in dental school. This lack of experience is extremely unfortunate for the individual dentist, the profession, the public, and the dental assistant. Such a dentist generally has little appreciation of the real value or importance of a well-trained dental assistant, and since he has not learned how to operate or function as a member of the team, much is lost in dentist operating economy and office economy even though he may be fortunate enough to employ an assistant who is well-qualified. It should be stated, too, that an experienced dental assistant may not be well-qualified, since she may have had one, five, or ten years of wrong experience.

The average dentist today is not fortunate enough to be able to employ a girl who has had a well-designed education and training program in a college or a school, since there are so few graduates and schools. Accordingly, he is obligated to employ a girl who has had "x" years of experience in another dental office, or a girl who has had no dental office experience. Frequently, the latter girl has not been screened carefully as to aptitudes and general qualifications. When a dentist who has had no training

in the effective use of a dental assistant employs a girl who has had no training or experience in a dental office, the blind leads the blind. How much does this cost the dentist, the profession, the public, and the dental assistant? The loss is great indeed.

In a number of years, many dentists through the trial and error method, learn a great deal regarding the economy of the dentist-dental assistant team. The latter dentist then may do a reasonably good job of training an assistant. The situation becomes more complicated in the fact that there is a large turn-over of dental assistants, since girls decide to get married or seek other employment. The entire process of selection and on-the-job training then must be repeated. Fortunately, for the dental profession the dental assistants of the country have done a remarkably good job in the average office even though there has been limited formal training. Then dental assistants, in general, must be complimented highly for this initiative and determination to succeed with the existing evident handicaps. The measure of their success is well documented. However, for the best interests of the dental assistants and all parties concerned, it seems logical that the status of the assistant be improved and that a greater economy of practice be realized.

There are several obvious solutions to the problems and situations cited herein. Some of the solutions are:

1. Adequate training of the dental student in how to use effectively a dental assistant.
2. Adequate training of the dental assistant prior to employment.
3. Adequate compensation for the qualified dental assistant.

The first two items have been discussed in part. There is no question that on-the-job training of the assistant must continue in the foreseeable future, until such time that there are enough schools to train girls to meet the demand for employment. Accordingly, the A.D.A.A. Extension Study Course will continue to be of prime interest to hundreds of girls throughout the country each year. The demand for the specially trained girl will increase markedly as the philosophy of the profession is modified regarding office and operational economy. This means that the dental schools must do a far more effective job of training the dental student.

There are many in the dental profession who also must learn that underpaid assistants are generally the most expensive, since loss of operational economy is indeed costly. The dental profession must recognize that the competition from business, teaching, and other areas of employment for talented qualified girls is keen, and that comparable salaries and benefits are essential if long tenure of employment is to be realized. Furthermore, girls and their families would be more interested in extended formal education and training, if employment in the average dental office becomes more attractive.

In addition to a more adequate salary for the average well-qualified assistant, and the social security benefits now realized, the dentist may consider one or more of the following as incentives to encourage long tenure of employees.

1. Formal contractual agreement as to vacation and sick leave. For example, the policy in some offices affords one day per month vacation and one-half a day per month sick leave. If no sick leave is taken the assistant can accrue 18 days of vacation per year.
2. Formal agreement regarding overtime service in the office. While working overtime should not be a routine policy, there are times when it is essential for the best interests of the patient and the office. Additional compensation should be realized by the assistant.
3. Blue Cross and Blue Shield or comparable health insurance. Such in-

surance is essential to the assistant and it provides a security which is meaningful.

4. A modest life insurance policy to remain in effect for the duration of employment.

There are other types of benefits which the dentist may direct to the assistant, and thereby assure a working relationship, loyalty, and interest that promotes longevity of service. Many dentists in the country have found this policy or philosophy of practice administration valuable.

Plan of Office Operation. A dentist may have the finest possible educational background, with six to eight years or more of formal education and training, with an office having the finest design and equipment, representing a total investment (office and education) from $20,000 to $30,000 or more, and then find his potentials for service to patients are very limited unless he has a well-qualified and trained dental assistant, and then, a definite plan of office operation. It is the dental assistant who first meets the patients in the reception room, and it is she who represents the dentist—with all of his years of training and investment until the patient is seen in the operatory. Likewise, the dental assistant represents and speaks for the dentist when the telephone rings, appointments are made, and assistance is given in the operatory.

The dentist must have a definite plan of operation, and then, he must delegate clearly the duties and responsibilities which the assistant is to assume. Such assigned duties and responsibilities should be written out, and they should be discussed at the beginning of employment and at other regular intervals. When questions arise, if there are two dental assistants, or one dental assistant and a secretary or additional employees, the duties of each must be defined clearly. The office without a well-defined plan of operation should expect to have many unwarranted problems relating to employees, patient misunderstanding, and fiscal affairs.

Every office has problems and situations which warrant discussions or conferences between the dentists and staff. A definite hour set aside from patient appointments and listed on the appointment book every two weeks, or at designated intervals, will do much to promote harmony, understanding as to duties and responsibilities, solution of problems, and thereby, efficiency in operation.

Policies, duties, and responsibilites must be identified and understood, and stated clearly in writing. They would include the following:*

1. Schedule of working hours of the assistant. This would include arrival and departure time, lunch hour, and policy regarding overtime.
2. Policy regarding salary and other benefits.
3. Office dress.
4. Housekeeping duties.
5. Extent and type of secretarial duties and responsibilities. This item would relate to: the system of bookkeeping, daily and other reports desired by dentist, extent of patient records to be processed by assistant, who (dentist, assistant or secretary) is to make the contractual arrangements with patients regarding costs for service and plan of payment, policy with reference to collection of accounts, policy regarding appointments, and the management of the recall system.
6. X-ray services. Who is to take x-rays, and under what conditions or situations are such pictures required?
7. Extent of chairside assistance desired by dentist, i.e., types of operations, management of instruments, and set-ups for various types of operations.
8. Sterilization procedures for various instruments and materials.

9. Policy regarding supplies. Who is to assume responsibility for ordering supplies, and determining minimum and maximum stocks to be retained in the office?
10. Policy regarding what, if any, laboratory work is to be done by the assistant.

**Duties and responsibilities would vary in offices depending upon location, type of practice, number and type of employees, i.e. dental assistant, secretary, hygienist, and laboratory technician.*

Office Design. Dental offices vary greatly in design and economy of function. A large percentage of the offices have no particular planning, except that a given amount of space was available and the dentist was obligated to utilize the area or rooms to the best possible advantage.

There now is evidence of considerable study and research in office design to permit greater operational economy on the part of the dentist, and too, the dental assistant. The fact that the dental cabinet is of a particular design, and that it generally is placed in easy reach of the dentist, is no reason to believe that such is the most desirable economically. There is considerable evidence that cabinets of varying design in back or at the side of the chair (back of the assistant) have many functional advantages.

Perhaps the most efficient arrangement or combination of rooms for an average office would include: a reception room, two operating rooms, a business office, a retiring room, a laboratory, and a dark room. It is assumed in the latter arrangement that the x-ray machine or machines would be in the operatory. This latter arrangement would provide for the employment of one or two dental assistants, or a secretary and a dental assistant. Ideally, this office combination should have a private office for the dentist, since the business office generally would be occupied by the secretary or one of the assistants, depending upon the operational plan of the dentist. If a dental hygienist is employed an additional operatory would be necessary.

The relationship of one room or area of the office to another will not be discussed here, since there are so many variables which must be considered in design of individual dentist's needs and experiences.

Summary and Conclusions.

1. The shortage of dentists and auxiliary personnel now and in the foreseeable future warrants serious consideration of all factors relating to economy of office operation. The potentials for a greater service to the public are realized thereby.

2. There is substantial data to show that a dentist cannot afford to practice without at least one dental assistant, and that two dental assistants are more desirable and economical.

3. Approximately one dentist in five presently does not employ any auxiliary personnel, and about one dentist in 20 employs two assistants.

4. To date, there is no general agreement in the profession as to what knowledge and skills the average dental assistant should possess.

5. The positive interest expressed in the education, training and qualifications which the dental assistant should have by the Council on Dental Education, the U.S. Public Health Service, a number of dental schools, and certain organized groups in the profession, indicates clearly that "special attention" is being given to this important member of the health team. The future looks brighter indeed for the dental assistant, with the further opportunities she will have for a career in this field.

6. The average dentist now is handicapped in achieving optimum office economy in the use of one of more dental assistants, since he has had little, if any, training in the use of an assistant while in school.

7. Greater longevity of service, and a greater attraction to a career in dental assisting, will be realized when (a) a more

adequate salary schedule is paid, and (b) additional benefits are made available.

8. Efficiency of office operation cannot be realized unless the dentist has a well-defined plan of operations.

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Efficiency In Gold Foil

By JEAN GOINGS*
York, Nebraska

Every operation in a dental office should become routine. Having a planned technique eliminates a waste of time, and improves the efficiency of the operation. Keep "your doctor" happy with a smooth running, time saving routine in GOLD FOIL.

Learn your doctor's operating routine, and build your set-up from this. By having articles laid out in the order they are used, your doctor can continue if for some reason you are called away. Be observant; you can always add new ideas that are time saving. The small seemingly unimportant things are what count.

I. POSSIBLE SET-UP:

A. Placing the rubber dam and preparing the cavity.
B. Condensing the Gold Foil.
C. Finishing and polishing.

A. Placing the Rubber Dam and Preparing the Cavity:

1. Cotton pliers, scaler, mouth mirror
2. Saliva ejector, air tip
3. Rubber dam holder on unit chair
4. Towel and napkin chain
5. Anesthetic
6. Correct hand piece on unit
7. Rubber dam—cut—rubber dam napkin
8. Cavity varnish
9. Rubber dam punch
10. Rubber dam clamp forceps
11. Petroleum jelly or shaving cream
12. Ligatures—cut
13. Instrument to assist with ligatures
14. Scissors
15. Matches
16. Compound
17. Burs for straight hand piece and contra-angle
18. Separators
19. Rubber dam clamps
20. Chisels and angle formers
21. Sandpaper strips for finishing the margin

B. Condensing the Gold Foil:

1. Foil pellets and Mat Gold
2. Gold foil carrier
3. Assistant condensor
4. Alcohol lamp
5. Matches
6. Condensor points
7. Condensor hand pieces
8. Neumatic condensor
8. Pliers for changing points

C. Finishing and Polishing:

1. Gold knives and Gold files
2. Burs and stones

Clinic, presented at the Annual ADAA Session, November 11, 1958, Dallas, Texas.

3. Separators if needed
4. Ribbon saw
5. Mandrels
6. Sandpaper discs and strips
7. Polishing paste — course and high lustre
8. Polishing brush and cup

II. HELPFUL HINTS:

a. Sharpen and remove stain from your carrier with sandpaper strips each time you are *finished* with a foil, then clean with alcohol before putting away.

b. Put one drop of oil in the motor each time when finished, this way you will neither over oil, or under oil the motor.

c. Have a small pillow to be placed under the patient's head after they have been in chair about 15 minutes, they will appreciate the added comfort. Have at least two pillow cases, so that there is always a clean one. Make it a point to put the clean case on in the presence of the patient.

d. There are many things you can anticipate, such as when the doctor uses a separator. When using a separator that can be used on either side of the tooth by changing the adjusting screw, you can look at the tooth and determine which side it is to be used, change the screw and have it ready for your doctor. When ready for use the adjusting screw is always at the top of the separator.

e. When lighting the match for the alcohol lamp, let it burn until the initial flame dies down .When the head of the match burns it produces sulfur fumes which may contaminate the wick. Hold the match to the side of the wick and not above it.

f. Keep the burs for the straight hand piece in a box with your Gold Foil equipment.

g. Always have plenty of foil rolled in ADVANCE.

III. ROLLING GOLD FOIL:

a. Wash hands thoroughly
b. Do not use hand cream
c. Do your work on a clean cloth
d. Have scissors and cotton pliers that are used for nothing but foil
e. Turn in the corners of the foil to make a round smooth surface
f. Roll foil loosely, so not to condense
g. Avoid all contamination as it can cause loss of time, as well as added expense

Broaden your knowledge and gain the ability to have a well planned schedule that will simplify the operation for your doctor, yourself, and the patient. In doing so, you will gain confidence, and the Gold Foil that might once have meant drudgery becomes a pleasure.

In Memoriam

Irene Louise Pray, member of the Oklahoma Dental Assistants Association, passed away October 30, 1958.

Irene was born in Pawnee, Oklahoma. For the past 18 years she has been dental assistant to Dr. W. J. Scruton of Oklahoma City. She became a member in 1948 and was active until the time of her death. She was Certified in February 1954.

She is survived by two sisters, Mrs. John Carruth, of Bristow, and Mrs. Carl Van Hooser, her identical twin, of Oklahoma City.

She is deeply missed by all who knew and loved her.

MAXINE SMITH, *Secretary*
Okla. Dental Assistants Assn.

3. Separators if needed
4. Ribbon saw
5. Mandrels
6. Sandpaper discs and strips
7. Polishing paste — course and high lustre
8. Polishing brush and cup

II. HELPFUL HINTS:

a. Sharpen and remove stain from your carrier with sandpaper strips each time you are *finished* with a foil, then clean with alcohol before putting away.

b. Put one drop of oil in the motor each time when finished, this way you will neither over oil, or under oil the motor.

c. Have a small pillow to be placed under the patient's head after they have been in chair about 15 minutes, they will appreciate the added comfort. Have at least two pillow cases, so that there is always a clean one. Make it a point to put the clean case on in the presence of the patient.

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MAXINE SMITH, *Secretary*
Okla. Dental Assistants Assn.

The Federal Narcotics Law In Relation To The Practice of Dentistry*

By ERNEST M. GENTRY, District Supervisor
U. S. Bureau of Narcotics, Dallas, Texas

I am aware of the contributions made by the medical, dental, pharmacy and allied professions to narcotic drug control in the United States and throughout the world. Narcotic drug control is based upon medical research and opinion which has established that drug addiction is not only harmful to the health of an individual but due to the tendency of addicts to create addicts through association, damaging to the health and welfare of a community or nation.

While historians report the medicinal use of opium and its abuses since hundreds of years before the birth of Christ, little attention was given to the problen until about the middle of the nineteenth century. Since that time narcotic drug addiction has been so complex, far-reaching and interwoven with health, commerce, and social customs that we might well ask if the use of opium or other narcotic drugs were ever confined to its sole valuable function as a therapeutic agent.

Narcotic addiction is not new in the United States. It first came to the attention of authorities in this country shortly after the Civil War. The problem first received attention in California during the coolie labor days. Smoking opium, during that time a legal import, was being brought from the Orient by white dealers and sold to Chinese, many of whom had acquired an opium habit prior to their immigration from China.

Due to the international concern created and after the signing of treaties arising from a world conference at Shanghai in 1901, the legal importation of smoking opium into the United States ceased and only small supplies of the drug which were smuggled have been encountered in the triffic in recent years.

Researchers inform us that the first white man who had developed the habit of smoking opium was encountered by authorities in San Francisco, California, in 1868. Shortly thereafter, others of the white race became addicted through association and the first anti-narcotic legislation in this country, and anti-opium smoking ordinance was enacted there in 1875.

With the migration of addicted Chinese laborers eastward and the introduction of opium usage into new areas, the problem spread throughout the United States. Following the invention of the hypodermic needle and with the discovery of heroin in Germany in 1898 by Dreser, opium smokers saw their supply of opium eliminated by import ban swung to heroin to satisfy their craving.

Addiction increased and youthful addicts were encountered. The situation existing in the early 1900's was similar to that of recent years where there has been much concern over the youthful addict who is loosely referred to as the "teen-age" addict. The addiction in this group was in the early 1900's and has been in recent years generally confined to individuals in their late "teens." This discovery was one of the factors which contributed to the enactment of the Harrison Narcotic Act in 1914 which outlawed the drug traffic.

* *An address given at the 34th annual meeting of the American Dental Assistants Association, November 12, 1958, Dallas, Texas.*

Narcotic drugs covered by this law are those included within the classification of opium, coca leaves, and any salt derivative, or preparation thereof. By an amendment approved July 1, 1944, to the Federal Law, isonipecaine, a synthetic substitute for morphine, was added to this classification and is thereof subject to the operation of the Federal Narcotic Law. By further amendment to the Federal law approved March 8, 1946, another category of drugs was included within the operation of the Federal Narcotic Law, this category being "opiate." An "Opiate" is defined to mean any drug found by the Secretary of the Treasury, after due notice and opportunity for public hearing, to have addiction-forming or addiction-sustaining liability similar to morphine or cocaine, and proclaimed by the President to have been so found by the Secretary. Examples of drugs which have thus been covered under the Federal Narcotic Laws as "opiates" are Methoden and Nisentil.

The two principal Federal Narcotic statutes are the Act of May 26, 1922, known as the Narcotic Drug Import and Export Act, as amended, and the so-called Harrison Narcotic Act now incorporated into the Internal Revenue Code. The Narcotic Drugs Import and Export Act authorizes the importation of such quantities only of opium and coca leaves as the Commissioner of Narcotics shall find necessary to provide for the medical and scientific needs. Importation of any form of narcotic drugs, except such limited quantities of crude opium and coca leaves, is prohibited. Exportation of manufactured drugs and preparations is permitted under a rigid system of control designed to assure their use for medical needs only in the country of destination.

The Harrison Narcotic Law as reenacted in the Internal Revenue Code is designed to direct the manufacture and distribution of narcotic drugs through medical channels to consumption use for medical purposes only. A dentist or other practitioner who intends to administer or dispense narcotic drugs in the course of his practice must apply for registration under the Harrison Law with the Director of Internal Revenue of the district in which he proposes to practice, and must pay the appropriate occupational tax for the year applicable. Before being entitled to such registration, however, he must be lawfully entitled under the laws of the State or Territory or district wherein he intends to practice, to distribute, dispense, give away or administer narcotic drugs to patients upon whom he, in the course of professional practice is in attendance. In the case of the dentist, this requirement usually means that the applicant is a dentist who holds an unrestricted license to practice dentistry in the particular State or Territory or district.

Every person making application for registry or re-registry as a dentist shall on December 31 preceding the date of his application, or any date between December 31 and the date for applying for such registry or re-registration prepare an inventory of all narcotic drugs and preparations on hand at the time of making such inventory. The inventory shall be prepared on the reverse of Form 678 and the face of the form completed to show pertinent data concerning the applicant. The completed Form 678, application for registration, with the inventory on the reverse, shall be forwarded to the Director of Internal Revenue and the duplicate shall be kept on file by the maker for a period of two years.

Upon approval of the application for registration the Director of Internal Revenue will assign a registry number to the applicant and will issue him a special tax stamp in Class IV as a practitioner. The special tax stamp must be kept posted conspiciously on the premises by the registration, i. e., the physician's office.

A dentist or other practitioner registrant who changes location of his office shall, within 30 days, execute a new return on Form 678, marking it "Revised Registry." The return shall be set forth the date of change and the new name or address. The return shall be forwarded with the special tax stamp to the Director of Internal Revenue who issued the stamp for recording the change. All unused official opium order forms should also be returned to the Director for cancellation and re-issuance showing the new location thereon. If the removal is to another State, Territory or district, the dentist must, of course, be qualified in the new location to administer, dispense, or distribute narcotic drugs to patients, which usually means that he must also be licensed to practice dentistry in the new location.

A dentist may secure narcotic drugs for direct dispensing or administration to patients only on official order forms. He may not obtain narcotic drugs on a so-called prescription for general office use. Official order forms are obtainable from the Director of Internal Revenue in a book, containing ten sets of original, duplicate and triplicate forms, for ten cents. The form is to be prepared in triplicate, and signed by the dentist, the original and the triplicate, together with the intervening carbon sheets, being forwarded to a qualified manufacturer or wholesaler and the duplicate retained by the dentist for a period of two years subject to inspection by a duly authorized Federal or State narcotic officer. The order form may be prepared in typewriting, ink or indelible pencil, but not by the use of an ordinary lead pencil. A dentist or other practitioner may issue for a bona fide patient, for medical purposes only, a prescription for narcotic drugs which may be filled by a qualified retail dealer (druggist).

A prescription for narcotic drugs shall be dated as of and signed on the date when issued and shall bear the full name and registry number of the dentist. A dentist may sign prescriptions in the same manner as he would sign checks or legal documents, as for instance, J. H. Smith, John H. Smith, or John Henry Smith. Prescriptions should be written with ink or indelible pencil or typewriter; if typewritten, they shall be signed by the dentist. The refilling of a prescription for taxable narcotic drugs is prohibited.

A dentist may not use his prescription form to obtain narcotic drugs for general office practice. Narcotic drugs desired for general office practice are obtainable on official order forms, as above described, from a qualified manufacturer or wholesale dealer. An order for narcotic drugs for general office practice, written on a prescription blank, is not lawful prescription within the meaning of the law and can have no effect to validate the sale which is illegal.

When the names of fictitious patients are discovered on narcotic drug prescriptions filed with a druggist it is usually a clear indication of wilful catering to drug addiction, whether or not the so-called prescriptions are also discovered to be forged. Sometimes the practitioner will insert a fictitious patient's name, however, because he wishes to conceal from the druggist the fact that the real patient is consuming drugs, notwithstanding that the real patient is claimed to have a bona fide medical need therefor. The law does not permit the use of a fictitious patient's name on a prescription.

The written prescriptions signed by the practitioner are required, the furnishing of narcotic drugs pursuant to telephone advice of practitioners is prohibited, whether signed prescriptions covering such orders are subsequently received or not, but in an emergency a druggist may deliver narcotic drugs through his responsible employee or agent pursuant to a telephone order, provided the employee or agent is supplied

with properly signed prescription before delivery is made, which prescription shall be turned over to the druggist and filed by him as required by law.

A retail dealer (druggist) may fill an oral prescription communicated to him by a duly licensed and registered practitioner for such narcotic drugs or compounds of narcotic drugs which the Commisisoner of Narcotics has found by regulations designated to possess little or not addiction liability. Such oral prescriptions however, may be filled only if State, Territorial or district laws authorize such procedure.

A practitioner's prescription blanks should be most carefully safeguarded and never left where persons who may be drug addicts will have opportunity to take them, and to prepare and have filled forged narcotic prescriptions. The order forms of a dentist should likewise be safeguarded, and great care should be exercised by the practitioner in keeping his narcotic drugs secure from robbery or pilfering.

If unused order forms are lost or stolen a report should be made at once to the Commissioner of Narcotics giving the serial numbers of the forms lost. In the event of a theft of narcotic stock, the practitioner should immediately report such theft to local law enforcement authorities for appropriate attention and thereafter file with the narcotic district supervisor a statement which must be signed, showing facts relative to the theft, including a list of the narcotics stolen, and documentary evidence that the local authorities were notified. This procedure should be followed also in instances of loss and a copy of the report to the Bureau of Narcotics should be retained with the narcotic records for a period of two years.

All Federal and State narcotic laws have been in force on a period of about a long generation. During this time the enormous advances in medical sciences and education together with enforcement of narcotic laws which included the control of the legitimate narcotic drug business, have reduced addiction.

I am sure that you will agree that the major tragedies of life are that so many things capable of doing the greatest good for mankind are capable of doing the greatest harm. Like primitive man who found that fire which could keep him warm would also burn his flesh, modern civilization faces the two edged sword in many ways — the automobile, atomic energy, and narcotic drugs.

Guideposts For The *New* Dental Assistant*

By RUBY CLEMENS
San Gabriel, California

YOU

I. ATTITUDE. Your attitude will determine the degree of success you will attain.
   a. Like dentistry.
   b. Like people.
   c. Respect your Doctor, your patients.
   d. Loyalty to your Doctor and your office.
   e. Take PRIDE in your work.
   f. Keep improving yourself, always.
   g. Keep improving your efficiency.
   h. Strive for EXCELLENCE in all that you do.
   i. Don't be critical of your associates.
   j. Be cooperative in all things.
   k. Have a sincere desire to be of service to humanity.

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* *Clinic, presented at the Annual ADAA Session November 11, 1958, Dallas, Texas.*

l. Delete the words, lazy, careless, failure from your vocabulary.
m. Be enthusiastic.
n. HAVE FAITH IN YOURSELF AND IN YOUR ABILITY.

II. RESPONSIBILITY. You are employed to *assume responsibility,* so prove that you have the ability to do so.
a. Careful planning of TIME, your Doctor's and your own.
b. All office procedure is STRICTLY CONFIDENTIAL.
c. Cooperation with patients and Doctor. (A repeat, but so important.)
d. Inspire confidence in your patients.
e. Loyalty and service to the practice. (Another repeat.)
f. Relieve Doctor of all responsibility except the practice of Dentistry.
g. Constantly watch for ways to improve office procedure.
h. Consider your patient's comfort always.
i. Use DIPLOMACY in dealing with all persons you come in contact with.
j. Be a SALESMAN for your Doctor and your office.
k. Be a BUFFER for your Doctor. With a kind and sympathetic approach you can do much in handling the "difficult" patient. The right approach can allay fear, irritation and dissatisfaction a patient might feel.
l. Use YOUR initiative.

III. PERSONALITY.
a. Develop an understanding of human relations.
b. Be sympathetic and kind.
c. Be courteous.
d. Be thoughtful.
e. Be pleasant and cheerful.
f. Be tactful.
g. Be honest.
h. Have self-confidence. This is assured by doing the very best you can.
i. Take a sincere personal interest in every patient.
j. Leave your personal problems at home, they're of no interest to the patients.
k. Conduct yourself with DIGNITY becoming to your chosen profession.
l. LIVE BY THE GOLDEN RULE.

IV. APPEARANCE. *Immaculate always!*
a. Daily shower, use an effective deodorant.
b. Clean cap.
c. Clean well-groomed hair in a becoming style.
d. Fresh uniform daily.
e. White hose, if possible, straight seams, no runs!
f. Spotless white shoes and clean laces.
g. White undergarments, as immaculate as your uniform.
h. Moderate make-up.
i. No eye shadow.
j. Sparkling TEETH.
k. SMILE. Always wear a smile for everyone who enters your reception room.

YOUR OFFICE

I. RECEPTION ROOM. This is your daytime living room, though *you* don't have time to sit and enjoy it, remember that your patient gets his first impression of the entire office here, IT MUST BE FAVORABLE!
a. Dust it first thing in the morning, and as often as necessary throughout the day to keep it spotless.
b. A few up-to-date, good quality magazines. Kept neatly stacked.
c. Clean ash trays as soon as person who used it is out of the room.
d. Fresh attractive flower arrangement, or an attractive planter
e. Inspect it hourly and keep it NEAT and PRESENTABLE.

II. OPERATING ROOM. Polish and clean all equipment weekly, oftener if possible. Clean cabinet drawers

OFFICERS OF NEW SOCIETY IN ILLINOIS-ST. CLAIR DISTRICT

Seated from the left are: Marjorie Harris, vice-president; Charlotte Burgess, president; and Juanita Little, DAA president. Standing from the left are: Marabeth Kampwerth, president-elect; Marjorie Mueller, recording secretary; Julia Bodnar, secretary-treasurer; and Maurine Wheeler, president-elect of IDAA.

weekly, and keep stocked with supplies at all times.

The operating room should never show evidence, to the patient being seated, that it has ever been used before; this means, do a *quick* but *thorough* clean-up job after each patient.

1. Clean Cuspidor.
2. Clean bracket table.
3. Spray bottles filled.
4. Equipment checked for *spatters*.
5. Wash bowl scoured and wiped clean.
6. Clean towels ready for Doctor and patient.

OTHER SUGGESTIONS:

a. Learn care of Handpieces.
b. Learn care of Contra-angles.
c. Learn care of Carbide burs.
d. Learn care of Diamond stones and wheels.
e. Learn how to change engine belts.
f. Keep pad handy for supplies needed and order before you run out.
g. Learn how to order supplies.
h. Have patient records ready for doctor.
i. Hand women patients tissue to remove their lipstick.
j. Know the instruments and where they belong.
k. See that patient is comfortable.
l. Keep *personal* conversation out of the operating room.
m. Don't bother Doctor when he is with a patient.

III. BUSINESS OFFICE. This should present the impression of an efficient, orderly, executive office. The *important* business of financial arrangements and appointment making is taken care of here, keep it NEAT and UNCLUTTERED!

a. Keep desk neat, dusted and uncluttered.
b. When posting record cards, do a few at a time, then return them to proper file.
c. Post record cards daily.
d. Keep files in order, up-to-date.
e. Learn as quickly as possible how to schedule appointment according to how your Doctor works.
f. TELEPHONE. Proper use of the telephone on the part of the dental assistant, is as important as proper

use of dental instruments in the hands of the Doctor. It is impossible to cover this here except to say it is usually the first contact you have with the new patient, SO learn how to handle all calls with a warm, friendly, interested voice. You can have a telephone personality as attractive as your "face-to-face" personality. YOU CAN HAVE A VOICE WITH A SMILE.

IV. LABORATORY:

a. Learn laboratory procedure.
b. Learn how to pour molds.
c. Learn how to carve inlays.
d. Learn how to invest inlays.
e. Learn how to cast inlays.
f. Keep a record of all cases as to when they are sent into the laboratory (commercial or your own) and when they are due back.
g. Record: MOLD, SHADE and other pertinent information re: each case.
h. There are many procedures, i. e. making trays, bite blocks. Learn and increase your value to your Doctor.

This has been given to you merely as a brief *preliminary outline* for the *new* dental assistant. It is an attempt to show you the vast opportunity to be of service to the Dental Profession. Also to point out that the career of Dental assisting can be a most interesting, varied, useful and gratifying experience. No other career offers the individual the opportunities to express various talents as that of the Dental Assistant, *artistic, mechanical* and *business* ability are all needed in the Dental Office.

Each day presents new experiences; new patients, new cases, new interests, so appreciate the privilege of following a career that never is monotonous, boring, and never "cut and dried."

MAKE PERFECTION A HABIT: It's as easy to do anything right as it is to do it wrong, it takes effort either way, so do it the right way.

Use this as a *check-chart*—add to it your own ideas and observations as you go along through the years—you'll find that this is "only the beginning."

Attention Please

Beginning with this issue we are discontinuing publication of the department, Views and the News. Part of the space formerly allotted to this department will be used, for the time being, to publish ADAA Committee information and instruction, which will be helpful to you in the planning and execution of programs in your state associations and local societies. Any additional available space will be used for articles of educational value. Send pictures of Clinicians (in action), along with clinic papers; pictures of officers of newly organized societies, and stories of outstanding educational programs, directly to the Editor. Deadline dates for copy to the Editor for the 1959 issues are: the first of February, April, June, July and October. Picture prices: full page, $12.90; one-half page, $9.25, one-fourth page, $7.60. Submit copy as follows: original copies (not carbons); typewritten, double spaced and on plain typing paper; not second (thin) sheets. Check your grammar and punctuation.

Why not enter the competition for the Best Essay Award by writing an article especially for publication in THE DENTAL ASSISTANT?

We have been informed that the editorial, "What The Day Demands," published in the November-December 1958 Silver Anniversary Issue, was written by Peggy LaLance, past president of the West Virginia Association.

*Office Personalities**

By Dr. Francis L. Bushnell
San Francisco, California

Some time ago, I listened to a speech given by Mr. James Robinson, Executive Secretary of the Southern California Dental Association. Mr. Robinson opened his remarks with the phrase "I'm strictly a blue sky speaker." Mr. Robinson has been speaking to all kind of audiences for nearly forty years with this same connotation. Here we have a lay person who tells the dental story so eloquently that in dental circles he is known as "Mr. Dentistry Himself."

I am not a "blue sky speaker" but I like to think of myself as a "blue sky thinker." I cannot help think that the dental assistant, who is so close and so essential to the dental profession should maintain the very same zeal for her chosen profession, bearing at least the responsibility of "blue sky" thinking in her dealing with her dentist's patients, associates and friends.

We do not have to look very far afield to be assured that the dental assistant can be most apt in the field of office public relations. After a relatively short time in a new situation in a dental office, she (the dental assistant) can be very well "tuned in" to her employer's innermost feelings regarding his practice. Knowing these things, she is armed with an ideology with which to confront the people with whom she comes in contact.

The dental profession is one in which there is little left to conjecture. We have at our command, positive diagnosis and treatment principles from which we can be very certain of the diagnosis treatment and prognosis of almost any situation. Therefore it is a relatively simple problem for the dentist to outline, in detail, a sequence of dental treatment for a patient. This being a fairly reliable truism, so much so that maintaining a practice becomes pretty much a routine, we can afford to place some emphasis upon the office philosophy. Now I say office philosophy but in reality, since thinking is pretty much alike in dental circles, this could very well be the dental philosophy.

To establish rapport with a patient or a parent, it is most essential that we be understood. We must not lost sight of the fact that every patient who enters the office wants something from us. These people want first to be felt welcome, and to feel that we are solicitous of their problems concerning dentistry. They feel that they deserve more than a cursory examination, but rather a complete, meaningful examination and inquiry into the nature of their problems. It would be well for each office to set up an examination procedure and some terminology exchange between the dentist and the recording assistant which is not too foreign to the patient, but not at the same time, frightening or startling to an apprehensive patient or parent.

Having once recorded the data from the digital examination and having taken whatever other diagnostic aids seemed to be necessary at the given moment, the patient should be allowed an addi-

**Presented at the ADAA General Meeting, November 10, 1958, Dallas, Texas.*

tional time with the dentist for further investigation and frank discussion. The History taken can be accomplished at the very same time, away from the dental chair, preferably in a consultation room where privacy is obvious. This is the time that we can tune in on the patient's feelings toward the dental profession and where very frequently we can be re-assuring to them in respect to previous and future treatment. At the same time, we can in general appraise the patient, or parent, of her or his needs and leave the door open for the patient to acquiesce to your recommendations or to refuse. If done properly, you will have very few refusals.

Except upon emergency situations, no dentistry is done in this first acquaintanceship period. Patients can be assured that after a complete study of their needs, treatment can be more accurately expedited. The first operative visit then should be the second, at which time the patient can be re-appraised exactly of what the dentist's intentions are, and quoted a fee. The patient already has had an approximate appraisal and appreciates an accurate one.

The foregoing is in general, a realistic notion of how people like to be treated in the dental office. This is true because we have put it purely on a personal basis. Now we can sprinkle in some other considerate treatment which can't fail to make a hit. The young aspiring dentist can note the birthdate of his child patients and remember them with a birthday card. The smart assistant could make mention of some favorite publicity given to one of the adult or child patients. If a patient calls in to break an appointment because of illness, send a get-well card. If a patient likes a nickname better than his given name, use it—but never give a patient a nickname.

Now let's assume that we have given this patient the full treatment—welcome, accurate determination of his or her needs, expedite remedy for his dental ills and considerate judgment in handling. It is then that the patient must realize we must be firm in exacting his consideration for the dental office. Most frequently there will be nothing but enthusiasm toward his discharging his obligations.

We like to be able to give patients alternates in methods of paying accounts. We like to verbally arrange budgets, not to extend beyond five months, with the explanation that in six months there should be no deterrent to a re-examination. If this is not possible, then in our state, we can offer the Dental Association post payment plan. Then finally, we have the not too infrequent one who will pay upon completion in full. We make these commitments with patients quite freely, knowing that we intend to keep the bargain. We like the absent third personality, in the form of our office auditor. He is the person who takes aging accounts out of our hands and presses for payment.

In reality, the office auditor doesn't do this at all. It is a collection firm who gives the office the benefit of three notices for payment at no charge to the office, with the understanding that if payment is not made in three months, that they will handle the account for collection at a fee.

The foregoing would seem, by itself, a very cool approach to the problem of being paid for a service. All along the way, however, this patient or parent has had every possible courtesy from the office. In addition, if need was apparent, he could very well be handed out "dribbles" of information regarding the cost of rendering dental service—not using too explicit terms. From this, if he is just a little understanding, he could not ethically refuse to defray the cost of the dental service rendered.

THE A. D. A. A. BOARD OF TRUSTEES 1958-59

Seated, l. to r.: 2nd V. P., Alicia King; Pres.-Elect, Joy Phillips; General Secretary, Corinne Dubuc; Immediate Past President, Magdalene Kulstad; President, Elma Troutman; Parliamentarian, Lillian Hoffman; Treasurer, Harriett Darling; 1st V. P. Lois Kyrger; 3rd V. P., LeVeta Lehn. Standing, l. to r.; 1st Dist. Trustee, Barbara Blomquist; 5th Dist. Trustee, Moselle Comer; 4th Dist. Trustee, Grace Browning; Chm. Past President's Council, Mary Haney; 6th Dist. Trustee, Ruth Maino; 7th Dist. Trustee, Ruth Asp 8th Dist. Trustee, Janice Jacobson; 11th Dist. Trustee, Helen Peterson; 10th Dist. Trustee, Elta Mae Selzer; 3rd Dist. Trustee, Anna Carey; 2nd Dist. Trustee, Alice Eder; 9th Dist. Trustee, Doris Arisman.

Through these pages we proudly introduce to the membership the 1958-59 Board of Trustees of the American Dental Assistants Association and the American Dental Assistants Certification Board; the Executive and Assistant Executive Secretary of the ADAA and the Executive Secretary of the ADACB.

A. D. A. C. B. Executive Secretary, Annette Stoker

On the shoulders of the ADAA Board of Trustees rests the responsibility for the 1958-59 year. Two months have gone by since these members assumed this responsibility, during which time each has no doubt given a great deal of thought and study to the work ahead. There is much to be done in the eight remaining months of this ADAA year.

This is the thirty-fifth board that has served the ADAA, and each has yielded something provocative and something constructive as the association has grown in size and in stature. The membership can be certain that this board will be no less diligent in its efforts to further that growth and progress. Certainly the challenge which confronts us today is too great and too important to demand less

than the best from each Officer and Trustee.

What about pay for all this? Well, each does receive a modest amount for office supplies and travel expense. But the real remuneration is in a kind of currency that is non-negotiable and non-transferable. It is the kind of "pay" that comes from serving others and supporting ideals in which we strongly believe.

The members of the ADACB are active members of the ADAA who were elected by its House of Delegates at the Dallas Meeting. These members contribute a service which is an important part of the educational program of the association in the interest of its individual members. Their remuneration is the same kind of non-negotiable, non-transferable currency as that received by the ADAA board members.

The Executive Secretaries perform duties that are important to the administrative affairs of the association and the certification board. While they receive as "pay" the kind of currency that is negotiable and transferable, their efficient attention to the duties delegated to them is vitally necessary for effective annual programs.

A. D. A. A. EXECUTIVE AND ASSISTANT EXECUTIVE SECRETARY

l. to r. Dorothy Kowlaczyk, assistant executive secretary; Mary L. Martin, executive secretary.

The individual members can make personal contributions by actively participating in the programs as set forth by our leaders. Let us be no less diligent in our share of the responsibility to insure the continued growth of our American Dental Assistants Association in the coming year.

THE A. D. A. CERTIFICATION BOARD 1958-59

l. to r.: Oriett Clark; Madge Tingley; Edna Zedaker, Vice-Chm.; Virginia Carpenter, Chm.; Dorothy Perry, Sec.-Treas.; Marie Perhall. Helen Searles and Dorothy Thacker not shown in picture.

A.D.A.A. STANDING COMMITTEES FOR 1958-1959

BUDGET & FINANCE COMMITTEE

Chairman, Mary Francis Dutton (past president); Corinne Dubuc, General Secretary; Harriet Darling, Treasurer; La Veta Lehn, 3rd Vice-President; Ruth Asp, Trustee.

BY-LAWS COMMITTEE

Chairman, Alberta Reed (Ohio); Vivian Esslinger (No. Calif.); Gladys Crawford (Idaho).

CLINICS & EXHIBITS COMMITTEE

Chairman, Merle Andrews (South Dakota); Ruth Shipley (Illinois); Terry Weber (New York); Letty Klocker (Ohio); Ruth Jones (So. Calif.).

AUXILIARY MEMBERS — 1 from each District

1st District,, Beth Auger (Mass.); 2nd District, Margaret Dougherty (New Jersey); 3rd District, Rosenna Hildebrand (Penna.); 4th District, Lillian Spears (Florida); 5th District, Frances Borders (So. Carolina); 6th District, Betty Moate (Wisconsin); 7th District, Irene Mills (Nebraska); 8th District, Audry Byington (Kansas); 9th District, Charlotte Tobler (Oregon); 10th District, Opal Smith (Texas); 11th District, Mary Delfino (No. Calif.).

COMMITEE ON EDUCATION

Chairman, Sadie Hadley (Texas); Ruth Doring (New Jersey); Lois Kryger (Washington); Mary Haney (Nebraska); Grace Browning (Alabama); Margaret Leedom (Nebraska); Virginia Carpenter, Chairman of Certification Board.

HISTORIAN

Chairman, Gertrude Carhart (New York).

JUDICIAL & LEGISLATION COMMITTEE

Chairman, Rozalie Polzer (So. Calif.); Ernestine Lurie (Alabama); Claire Williamson (Georgia); Rose Donohue (Penna.); Marie Ramsey (Wisc.); Corinne Dubuc, General Secretary.

ADAA LIFE MEMBERSHIP COMMITTEE

Chairman, Helen Fitting (Penna.); Katie McConnell (Georgia); Mildred Rinn (Illinois).

MEMBERSHIP COMMITTEE

Chairman, Ann AuBuchon (Mo.); 1st District, Florence Veins (R. I.); 2nd District, Gertrude Carhart (New York); 3rd District, Marjorie Baerncopf (Penna.); 4th District, Bobbie Oxar (Florida); 5th District, Ann Lanier (Tenn.); 6th District, Joyce Carey (Indiana); 7th District, Mathilda Bremer (Minn.); 8th District, Edna Trower (Mo.); 9th District, Helen Schwartz (Washington); 10th District, Laura Jordan (Arizona); 11th District, Lucille McIntyre (So. Calif.).

NOMINATING COMMITTEE FOR 1959

Chairman, Magdalene Kulstad (So. Calif.); Laura Armanini (Ohio); Billie R. Noack (Arizona); Louise Huntsinger (Florida); Marie Perhall, Member of Certification Board.

ADAA PAST PRESIDENTS COUNCIL

Mary Haney, Chairman; Marie Shaw, Vice-Chairman; Ruth Doring, Secretary-Treasurer.

PIN COMMITTEE

Chairman, Mary Faler (Ohio); Pauline Ramsey (Texas); Faye Jackson (Wyo.).

PROGRAM COORDINATION COMMITTEE

Chairman, Alicia King, Vice-President; Juanita Little (Illinois); Mary Mosier (Indiana); Olive Steinbeck (Florida); Lucille Petty (Utah).

PUBLIC RELATIONS COMMITTEE

Chairman, Anna Carey (Ohio), Trustee; Sue Allison (Dist. of Col.); Florence Smith (New Jersey); Lois Kryger, Vice-President; Violet Crowley, Editor.

J.A.S. RELIEF FUND

Chairman, Eugenia Uttech (Wisconsin); Maxine Bartholomew (Michigan); Margaret Nolan (Washington); Lillian Sparks (Ohio); Harriett Darling, Treasurer.

J.A.S. SCHOLARSHIP

Chairman, La Veta Lehn, Vice-President; Evelyn Brett, Past President (Penna.); Harriett Darling, ADAA Treasurer.

ADAA SPECIAL COMMITTEE — CIVIL DEFENSE COMMITTEE

Chairman, Lillian Callicutt (North Carolina).

CERTIFICATION BOARD DIRECTORS

Chairman, Virginia Carpenter; Edna Zedaker, Vice-Chairman; Dorothy Perry, Secretary-Treasurer; Helen Searles, Dorothy Thacker, Marie Perhall, Madge Tingley.

The American Dental Assistants Certification Board, Inc.

General Information Booklet

RULES AND REGULATIONS

Function:

1. To approve questions for written and practical examinations and to provide qualifying examinations for eligible dental assistants.
2. To process examination papers and issue certificates to all successful candidates.
3. To maintain a register of all applicants and those receiving certificates.
4. To make all decisions relative to applicant's eligibility to be examined, and reserve authority of final decision regarding certification of any candidate.
5. To specify the two periods during which examinations are held.
6. To provide application forms for examination.
7. To check all orders for Certification wreaths before orders are forwarded to jeweler.

Rules and Regulations for Certification

1. All applicants must be active members of the ADAA. Where a question arises as to membership status, the membership record of an applicant for certification as recorded in the files of the ADAA's Central Office, will be accepted as final proof of eligibility.
2. Applicants for certification by the Board shall be high school graduates, or have the equivalent education of such graduates.
3. Applicants shall have completed courses approved by the ADAA or graduated from schools approved by the ADAA or schools of oral hygiene accepted by the ADA Council on Dental Education.
4. Applicants shall have been employed in ethical dental offices, clinics, institutions or hospitals.
5. Applicants must pass successfully the examination of the ADACB, INC. and certification will be made available to them when they have met the following requirements:

a. Graduates of two year courses in ADAA approved schools, having Active membership, may apply for the examination held in their state. Certification will not be granted until a one year employment requirement is met. Active membership is also required at the time the certificate is issued.

b. Graduates of one year courses in ADAA approved schools, having Active membership, may apply for examination held in their state. Certification will not be granted until a two year employment requirement is met. Active membership is also required at the time the certificate is issued.

c. Active members who have completed the ADAA approved extension study course or the approved correspondence course, and have been employed in an ethical dental office, clinic, institution or hospital for a period of two full years may apply.

d. Granduates of schools of oral hygiene accepted by the ADA's Council on Dental Education and having Active membership may apply upon meeting a two year employment requirement. NOTARIZED PROOF of the above educational and employment requirements shall be obtained by the applicant and must accompany the application.

6. Application for examination shall be made on a form provided by the Board and accompanied by an examination fee of $15.00. No application shall be acted upon until the examination fee is received by the Executive Secretary.

7. An applicant shall not be given a refund for failure to take the examination at the designated time and in no case shall the examination fee be refunded unless in the opinion of the Board the applicant is deemed ineligible for examination. Written reason for non-appearance at examination must be furnished to the Executive Secretary of the ADACB within 30 days after date of exam.

8. Any applicant desiring re-examination by the Board shall be required to file a new application and pay the examination fee of $15.00.

9. Independent qualified members of the ADAA, who are not affiliated with a state association or local society may be granted the privilege by the ADACB of taking the examination at the state association or local society most convenient to their residence.

10. Eligible Active members satisfying the educational and employment requirements in one state, who move to another state *before examination date,* may apply for examination with the new state, provided they affiliate with that state association. They must furnish proof of their education and employment requirements, and if they have moved within the same calendar year in which the exam is to be given, their applications must be countersigned by the Secretaries of both states.

Examinations

1. The examination shall include a Written examination and a Practical examination. The applicant must have a passing grade in BOTH the Written examination and the Practical examination to become certified.

2. All examinations shall be provided by the Board of Directors of the ADACB.

3. Examinations shall be held only during examining periods specified by the ADACB.

4. State Associations (or local society where no State Association exists) may hold examinations at centers convenient for the majority of the

applicants BUT only ONE examination per period for EACH center.

Examining Periods Shall Be:
May — 2nd Wednesday through Sunday
October — 2nd Wednesday through Sunday

5. Choice of examining centers and publishing notice of same shall be the responsibility of the individual state association.
6. The President of the State Association shall appoint examining committees as needed, all of whom must be CERTIFIED Dental Assistants. Chairmen of Examining Committees shall be designated by the State President.
7. Chairman of each Examining Committee will receive the examination papers for which she will be responsible until their return to the Executive Secretary of the ADACB.
8. Each Examining Committee shall provide a suitable place, supplies and equipment for holding both Written and Practical Examinations.
9. Sufficient time shall be allotted for examinees to complete entire examination.
10. Ethical Dentists should be asked 30 days in advance to supervise the Practical Examination and grade same according to instructions provided by the ADACB.
11. Each Examining Chairman shall seal all Practical and Written examination papers and all companion material in envelopes provided, AND RETURN IMMEDIATELY BY REGISTERED OR CERTIFIED MAIL to the Executive Secretary of the ADACB.

Procedures for Examination

Step One: The local Education Chairman shall inform the State Education Chairman of the number of applicants for examination.

Step Two: The State Education Chairman shall then inform the State Secretary of the number of applicants.

Step Three: The State Secretary then shall supply the ADACB Executive Secretary with the following information:

a. number of applications needed
b. date selected within the examining period
c. names and addresses of examining Chairmen.

Step Four: The State Secretary mails application blanks to applicants. When completed applications, INCLUDING AFFIDAVITS AND FEES, are returned to State Secretary, she shall check Active membership eligibility of each applicant, sign each application, and return applications with affidavits and fees to the Executve Secretary of the ADACB.

Procedure Dates for Above Steps

MAY EXAMINATION

Step One — by January 1st
Step Two — by January 10th
Step Three — by February 1st
Step Four — by March 1st

OCTOBER EXAMINATION

Step One — by June 1st
Step Two — by June 10th
Step Three — by July 1st
Step Four — by August 1st

Specific instructions for conducting the Examination will be sent to the Examining Chairman by the Executive Secretary of the ADACB.

Insignia of Certified Dental Assistants

1. The emblem of the ADAA in the form approved by the ADACB may be worn on the upper left hand corner of cap by assistants who have been Certified. These may be purchased from the Executive Secretary of the ADACB at a cost of three for fifty cents.
2. Active Certified members of the ADAA are entitled to wear the Certification wreath approved by the ADACB and the ADAA attached to the ADAA emblem pin.

The Dental Health Team*

By Dr. Walter Dundon†

I am interested in the formal training and education of the dental assistant. All of us have heard the point made — so many times that it is almost a theme of sorts — that the dentist can take a girl out of high school, or from behind the counter of the corner drug store and, assuming a reasonable amount of intelligence, make an acceptable dental assistant of her in just a couple of years. This dentist, as the theme is usually stated, can teach such a person the mechanics of working in the dental office, even though such instruction is given at the expense of his own very valuable time. I am willing to be on record as stating that this type of training program is neither a proper, nor an efficient one, for a profession which places a high value on the work of its own members and members of the auxiliary groups which serve it. Even further, a vocation whose requirements can be met through simple, and often haphazard one-the-job training programs, a vocation for which there are generally recognized educational standards, and a vocation for which the training of its key personnel is any man's meat — a vocation such as this, will attract neither the quality, nor the numbers of persons, that I am sure the dental profession will need in the future as dental assistants.

With such a preamble as this to my brief talk with you today, I think that you can see that your President-elect, Miss Elma Troutman, has been both considerate and perhaps just a little bit contriving in assigning to me the topic of "The Dental Health Team" for this meeting. With your indulgence then, I am going to use these few minutes with you for some phophecy — and this is why I have asked your indulgence. I am neither a prophet nor a soothsayer, although in a general way, I intend to assume such a role in presenting my thoughts to you on a general, but never-the-less important, theme.

I am one who believes quite strongly that the future of the dental profession will require even more teamwork between the dentist and his auxiliaries than what we can now observe. In the next five to ten years dentists will need assistants, hygienists, and laboratory technicians in even greater numbers than today. This is a safe, but none-the-less significant statement, and it can be supported with statistics that are now available.

The population of this country is increasing at the rate of nearly three million persons a year. By 1970 the national population probably will be in excess of 220 million and by 1975 it will be nearly 230 million. We have a current population of about 175 million people, and against this, there are some 90,000 dentists in active practice to serve this population. This gives us a national ratio of about one dentist to 1,679 of population. Most of the leaders of the dental profession feel that, though this figure represents a fairly satisfactory level of dental health service to the pub-

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* *An address given at the 34th Annual Meeting of the American Dental Assistants Association, November 12, 1958, Dallas, Texas.*

† *Past President of The Chicago Dental Society; Past Chairman Council Dental Trade Laboratory Relations, American Dental Association; now 3rd Vice-President, American Dental Association.*

lic, this service level is already worsening, in that the population is increasing faster than our dental schools can graduate dentists to serve the growing population* It is now estimated that, to maintain the dental health service level of 1955 (which was somewhat better than it is now in 1958), an additional 600 dentists each year are needed over and above the present figure of 3,000, which the schools now graduate. To accomplish such an objective, the present 47 dental schools must find ways to expand existing programs and teaching facilities and the profession must give encouragement and assistance in the building of perhaps another ten new dental schools in the next decade and a half.

The fact is, that the schools *are* expanding existing programs and they *are* planning to expand their teaching facilities. Current surveys (January 1958) show that a $49 million program of new construction and remodeling of buildings is now in the blueprint stage and will be carried out within the next five years. An additional five years beyond this will undoubtedly see an even further expansion and remodeling program undertaken. Yet few, if any, persons concerned with the need for more dentists by 1970 and 1975, feel that this program will be entirely adequate in enabling the dental profession to keep the present satisfactory level of dental service ratio intact. It is more commonly recognized than ever before, by leaders of the dental profession, that the task of keeping this service level at least as high as it is now will require a greater task force of all the dental auxiliaries than we have today. The profession's inability to keep up with population growth in numbers of dentists to population can be bridged through the training and use of greater numbers of dental auxiliaries. This outlook applies to the education of dental assistants, as well as to the hygienists and technicians.

To continue in the role of prophet which I have assumed today, I will further predict that more dentists in the next ten years will be trained while yet in dental school to use and want the services of auxiliary personnel, as they establish their own practices after graduation. The pattern of practice established by the more recent dental school graduates points to this trend, and you can be sure that such a pattern will continue in the next several years to be even stronger than it is now. Our younger dentists now realize that their ability to provide dental care to increasing numbers of people will depend more than ever on "teamwork." This means, teamwork among the dentists, the assistants, the hygienists and the laboratory technicians. By 1968, an additional 30-40,000 dentists will be imbued with the need and importance of such teamwork to the public welfare and to their own future careers.

Those of you who have followed the affairs and the growth of the dental profession as long as I have and who have contributed as many years of service to its developing stature as one of the major health professions, will realize that I am not a prophet. Actually, there are directives and actions of the Association's House of Delegates of fairly recent date which will bear out most of the statements which I have so far made.

Let me glance down again, at my crystal ball. Does it interest you that I would predict that by 1968 there will be an additional five to eight new dental schools already built or under construction? This will, of course, represent an attempt by the profession to close the gap between the number of dentists and the number of people we are expected to

serve at this date. Of more direct interest to you, however, is the conviction which I have, that more of the *present* and more of the *new* dental schools will have training programs for assistants, hygienists and laboratory technicians along with the dental school program.

Last January a survey revealed that even in the next five years eight dental schools plan to add the following training programs for dental auxiliaries: 8 for dental assisting; 7 for dental hygiene and one for laboratory technicians. Further than this, if some form of federal aid becomes available to the 47 schools who reported in the survey, auxiliary training programs would be added to existing dental school programs as follows: 17 for dental assisting, 10 for dental hygiene and 7 for dental laboratory technicians.

Of considerable interest also, is the existence of six pilot studies in dental assisting that are being sponsored by the Public Health Service in as many dental schools. These pilot programs are studying the methods of training dental assistants and the methods of training dentists in the most efficient use of assistants in the dental practice. It seems more than evident that the two-way educational process for dental assisting is progressing in a manner quite favorable to some of the objectives about which I am speaking.

While it is good to see that dental schools themselves will become more interested in the training of the dental auxiliaries in the next few years, I feel just as sure that educational programs for all three of the auxiliaries will undergo an expansion in numbers in schools and institutions other than dental schools. To say this in another way, I would predict that more institutions of all kinds will become more attentive to the education of dental auxiliary personnel within the next ten years than do so today.

Approximately 1,000 hygienists are being graduated each year by 34 schools. Nine of these are located in schools other than schools of dentistry. Even at this current rate of graduates, this auxiliary group is turning out only enough hygienists to replace those who are lost to the profession each year through death, retirement, marriage and other personal reasons. It is interesting that there is so far no net annual gain of hygienists for the dental profession to absorb from these 34 schools. Perhaps another 10-15 schools will be needed to produce this needed annual net gain.

While the hygienists are graduating each year at least as many persons as they are losing through death, retirement and marriage, etc., the laboratory technicians will need to spend the years from 1958 to 1970 in establishing programs in dental laboratory technology at schools and institutions across the country. As you know, the new education and certification requirements for this auxiliary arm of dentistry were approved at Miami in 1957 and some time yet will be needed to establish even as many as ten new schools in this craft.

Insofar as training and certification are concerned, your own organization is much more fortunate. Your education committee now has approved 23 educational programs, nine of which are two years in length, five are one year in length, eight are 104 hour extension study courses and one, a correspondence course. Your education committee, Certification Board and the officials of both the Association and the Certification Board can well be proud of the work you have so far done in establishing education and certification standards in this field of auxiliary service. Yet, without being in the least derogatory about these accomplishments by your organization, in speaking as an official of the American Dental Association, I think that you would all agree that the

dental health team will not be complete and fully developed until the education and certification of dental assistants programs becomes the responsibility of the dental profession and specifically, the Council on Dental Education. When this recognition is obtained — and I have every reason to believe that it will be, in the not too distant future — educational programs for dental assistants will then increase in numbers and improve in quality, just as is now the case for the other auxiliary groups. It would seem likely that there will be increasing numbers of one and two year courses, short extension type programs and perhaps too, a growth in the numbers of correspondence courses.

The future of the dental profession is one of expanding need for more and better trained dentists; the future of each of the dental auxiliaries is no less the same. In the years ahead, the education and training of dental assistants will undergo much change and improvement — just as it has in the past ten years or so. Each of the dental auxiliaries will become immeshed in this very sure trend of the profession and the teamwork concept for the dental practice of the future will be increasingly important in the over-all picture of dental education. But even more important than these forecasts of things to come in our immediate future is the fact that these are not idle dreams or visionary comments. The statistics of population growth will support each of these forecasts with uncommon accuracy.

I am sure that by now, all of you realize that it is not difficult to be a prophet — not difficult at all, that is, when you are supported by the armamentarium of facts and statistics upon which these remarks have been based. Before concluding this paper, and with some considerable humility in my capacity as an official spokesman for the dental profession, I would like to summarize these forecasts as briefly as possible:

1. Because there will be a need for more dentists by 1975 than the present number of dental schools can possibly graduate, I predict that the number of dental assistants to be trained will be increased in a direct ratio to the number of dentists that will be needed to maintain 1955 levels of dental care; this perhaps might represent a two-fold expansion of your present numbers.

2. Along with the expected expansion of the population and the need for more auxiliary personnel in the years 1958-1975 will obviously come the need to expand the number of existing training programs and to establish additional new ones.

3. Because the dental profession is now very much aware of the probable dental manpower shortage within the next ten years or so, I predict that the dentist of the future will be thoroughly trained in the proper use of the assistant, the hygienist and the technician and that each of these auxiliaries will be in even greater demand by dentists than they are today. Career opportunities in the auxiliary services of the health professions have never been better.

4. Existing dental schools and the new dental schools of the future will offer auxiliary training programs adjunctively with dental school programs.

5. The number and types of training programs for the dental assistant will be significantly expanded and improved by 1975.

6. And finally, in the near future, education and certification of the dental assistant, under programs approved and accredited by the American Dental Association, will be a reality and not just an informal conjecture, as it must be at this time.

I would like to think that my presence here this morning and my appearance on your program as an official rep-

resentative of the dental profession as a symbol of the future relationship between our associations. The spirit of teamwork between the American Dental Association and your Association that has characterized the past, I know will be continued in the future. I know that all of you have a very keen interest in having your education and certification programs identified with the dental profession on the basis of its official recognition, as is now the case for both the hygienist and the laboratory technician but I hope that, as an association, you will not be like the fellow who went out mountain climbing with a friend and very carelessly lost his footing. This man fell 560 feet to a small ledge that was jutting out from a steep slope. As soon as his partner at the top had recovered from the shock of seeing his friend fall he leaned over the edge and shouted, "Are you all right?" The man on the ledge yelled back, "Think so. Get some rope," So the partner at the top scurried off and brought back some rope and proceeded to let it down over the edge of the cliff until he had released exactly 560 feet to his unfortunate partner. Then he cupped his hands again and yelled down, "Tie it around your arms!" Pretty soon the reply came back, "Can't. Arms are broken." So the fellow on top, still desperate, but still rational, too, cupped his hands again and once more yelled over the cliff, "Tie it on your legs, then." Again, but more painfully, the reply came back, "Can't. Legs are broken!" Finally the man at the top got one more desperate idea and so again he cupped his hands and shouted down to his friend, "Hold on with your teeth then!" The man on the ledge finally yelled a groaning, "O.K.", and at that, the man on the top of the cliff slowly started to pull his friend up the treacherous mountain slope. Inch by inch and foot by foot, he strained and pulled and pulled and strained until he had the man raised about 555 feet from the little ledge. He paused a minute to rest and looked over the side to give his friend a final word of encouragement and asked, "How do you feel?" and the man on the rope replied, "Fiiiiinnnnnnnneeeeeee!"

Ladies, please don't let go of the rope! You are almost at the top of the cliff.

Syl Sez:

HELLO FROM THE EMPIRE STATE!

In September we will be gathering in New York City to conduct the business of the 35th Annual Convention of the American Dental Assistants Association. In addition to the celebration of our 35th birthday, we will join in the celebration of the centennial year of the American Dental Association... A gala year and a gala celebration are in store.

There will be scientific sessions, and social events such as: a welcoming tea; a presidential banquet; sightseeing in the world's greatest city, by land and by river; shopping in the vast fashion centers — from 14th to 57th Streets, from 5th Avenue to 6th — to Suburbia— something for everyone. So, start your planning now, check with the members in your local and state society and come in groups (it will be less expensive that way). If state presidents will send this reporter your plans, we can synchronize them for a high-flying Convention— the ADAA's 35th.

COME EARLY, STAY LATE, MAKE YOUR 1959 DATE — THE EMPIRE STATE.

SYLVIA DANNENBAUM,
Chm., Publicity 1959,
700 West 175th Street
New York 33, N. Y.

application for housing accommodations

Centennial Session, American Dental Association
September 14-18, 1959 — New York

- Reservation requests for housing accommodations should be made by completing this application and mailing it to American Dental Association, Housing Bureau, P.O. Box 5440, Chicago 7, Illinois.
- *Make your reservation now!* Assignments to hotels will be made in order received.
- Scientific session and exhibits will be held in the Coliseum. Meetings of the House of Delegates of the American Dental Association will be held in the Waldorf-Astoria Hotel. Meetings of the Federation Dentaire Internationale will be held in the Manhattan Hotel.
- Indicate your arrival and departure time in New York on the application. Reservations will be held only until 6 p.m. of the day of arrival unless specific arrangements are made with the hotel.
- If rooms are not available in the hotels listed on the application, an assignment will be made, whenever possible, to a hotel in the same area.

American Dental Association Housing Bureau, P.O. Box 5440, Chicago 7

PLEASE PRINT OR TYPE — A.D.A.

APPLICANT

Name_____

_____
STREET ADDRESS — CITY — ZONE — STATE

Arriving_____ a.m. p.m. Leaving_____

ACCOMMODATIONS

Hotel or Motel_____ (FIRST CHOICE) Hotel_____ (THIRD CHOICE)

Hotel or Motel_____ (SECOND CHOICE) Hotel_____ (FOURTH CHOICE)

☐ Single occupancy, rate to range from $____ to $____ per day.
☐ Double occupancy, double bed, rate to range from $____ to $____ per day.
☐ Double occupancy, twin beds, rate to range from $____ to $____ per day.
☐ Suite of ____ rooms, including parlor, rate to range from $____ to $____ per day.
} 2 names must be listed below

Room will be occupied by:

_____
NAME — ADDRESS — CITY — STATE

_____
NAME — ADDRESS — CITY — STATE

WHEN & WHERE

AMERICAN DENTAL ASSISTANTS ASSOCIATION:

Thirty-fifth Annual Session, September 14-18, 1959; New York City, New York.
Headquarters: Statler-Hilton Hotel.
General Secretary: Miss Corinne DuBuc, 156 Broadway, Pawtucket, R. I.
Executive Secretary: Mrs. Mary L. Martin, 410 First National Bank Bldg., La Porte, Indiana.

STATE ASSOCIATION MEETINGS

SECOND DISTRICT

State	*Date*	*Place*	*Secretary*	*Address*
New Jersey	May 12-13, 1959	Hotel Traymore	Jane Raynolds	45 Church St., Montclair
New York	May 10-13, 1959	Syracuse Hotel Syracuse, N. Y.	Mary E. R. Keegan	3341 29th St., Astoria 6, Long Island, New York

FOURTH DISTRICT

State	*Date*	*Place*	*Secretary*	*Address*
Alabama	April 20-22 1959	Redmont Hotel, Birmingham	Lillie Mae Hurst	P. O. Box 787 Gadsden
Florida	May 17-20 1959	Diplomat West Hollywood	Florence Ruud	2701 N. Flagler Drive, West Palm Beach
Georgia	Oct. 25-27 1959	Dinkler-Plaza Hotel, Atlanta	Joy Jones	1987 Willa Way Decatur
Louisiana	April 2-3 1959	Washington-Youree Hotel, Shreveport	Evelyn Smith	1949 Vivian Street Shreveport
Mississippi	June 21-24 1959	Buena Vista Hotel Biloxi	Laura Hodge	P. O. Box 945 Corinth

NINTH DISTRICT

State	*Date*	*Place*	*Secretary*	*Address*
Oregon	March 2-4	Portland	Dorothy Blattner	637 N. E. 21 Portland, Ore.
Washington	April 6-8	Seattle	Marilyn Scott	Port Angeles, Washington
Montana	May 7-9	Kalispell	Emma Lind	Medical Arts Bldg. Butte, Montana
Idaho	June 22-24	McCall	Barbara Fisher	212 N. Walnut Boise, Idaho

Ed. Note: Meeting dates of other state associations will be published as this information is received.

Help Yourself

EDITED BY JANET LINDENBERG

Circle numbers in the telephone directory (that you use frequently) and they will be easily and quickly located when you need them.

* * *

Your voice must do the job of conveying personality in telephone conversations. Place a mirror near your telephone to check your lip movement for better enunciation — a smile on your face will put a smile in your voice.

* * *

Keep several sharp pencils, a ball point pen, an eraser, a calendar and appointment slips near the appointment book.

* * *

The National "500 notebook" has 500 words frequently misspelled; it can be a convenient reference for the business office.

* * *

A friendly letter to prosthetic patients, in which you review oral hygiene instructions and invite the patient to come in to have dentures repolished, can serve as a reminder to anticipate mouth changes that may necessitate relining of his denture.

* * *

Efficient organization of work serves to utilize the Doctor's and your time to the best advantage. It will eliminate additional hours that result in "Office Fatigue."

* * *

Keep an eyeglass rack and tissue dispenser within easy reach of the patient when he is in the chair.

* * *

Cabinet drawers lined with white oil cloth are easier to clean, and the cloth does not need to be changed as often as paper liners. The corners will not curl or tear.

* * *

Rubber bands placed beneath the bulges of the spray bottles in the dental unit will reduce breakage, as this helps absorb shock when the bottles are heated.

* * *

For convenience keep a sponge handy to wipe up things that are accidentally spilled.

* * *

Keep the retiring room well ventilated. The after effects of anesthesia vary with patients.

* * *

An easy method for storing inlays until the Doctor is ready to seat them is to place the inlay in a small celluloid crown holder and paste the patient's name on the outside — this will avoid loss of a piece of work that required the Doctor's time to do.

* * *

In adapting plastic patterns to full denture wax-ups, spray the backs of the patterns with acrylic spray "bomb." The patterns adapt more easily, there is less possibility of bubbles forming and they do not tend to pull away from the teeth.

* * *

Keep a jar of water at room temperature in the laboratory for mixing impression materials.

THINK IT OVER —

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CARVING HINTS

FOR THE DENTAL ASSISTANT

Pontic Contour—Occlusal Surfaces

Fig. 1

A pontic must restore function, be hygienic, meet esthetic demands, and it must be bioligically acceptable to oral tissues. To fulfill these requirements some changes from normal tooth form (shown in Fig. 1) are necessary.

Fig. 2

Fig. 2 shows a 3 unit bridge. Narrowing the bucco-lingual width of the occlusal surface reduces the area exposed to masticatory forces. The lingual embrasures are widened to facilitate self-cleansing action and easier patient care.

Fig. 3

Fig. 3 shows a 4 unit bridge. When lengthening the span, the occlusal surfaces are reduced still further. Both short and long span bridges have supplementary occlusal grooves and lingual spillways to prevent the packing of food in the occlusal fossae.

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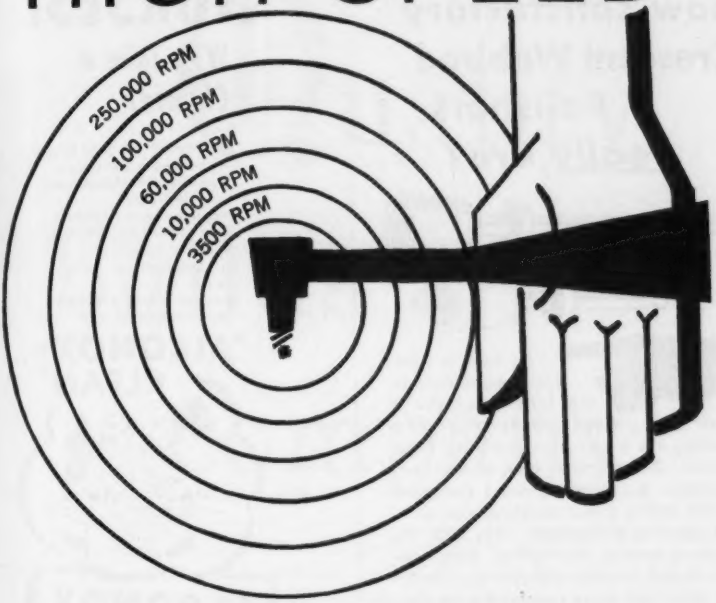

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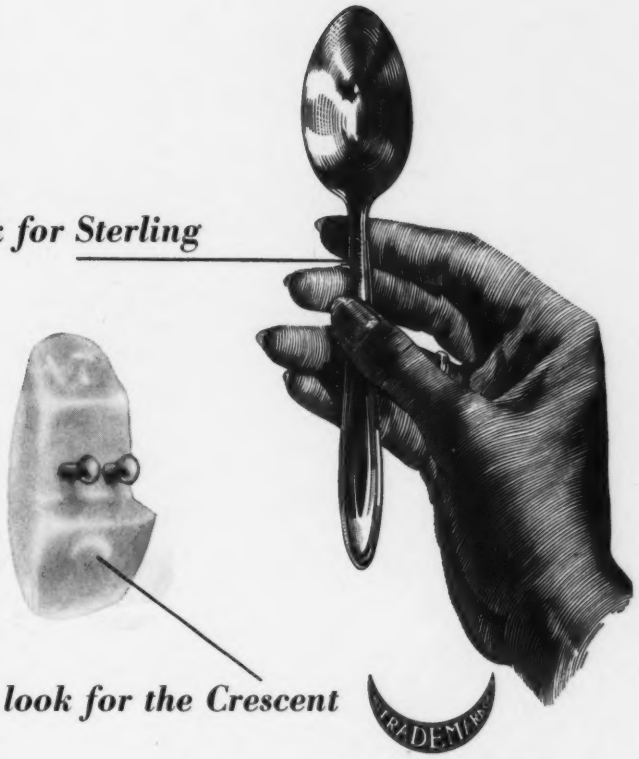

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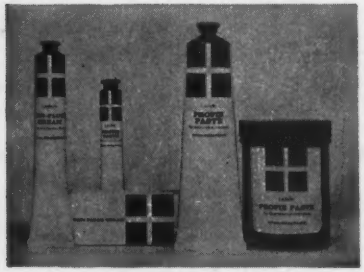

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